



PAR Index Recording Form

For instructions on completing this form, see Appendix D of the Dental Manual.

Date of Examination: _____

Provider

Name: _____

Provider No.: _____

Telephone No.: _____

Patient

Name: _____

ID No.: _____

Birth Date: _____

PAR Index Components	Before Treatment	Total	After Treatment	Total
Upper Anterior Segment	R (3-2)___ (2-1)___ (1-1)___ L (1-2)___ (2-3)___	UW W ___ x1 ___	R (3-2)___ (2-1)___ (1-1)___ L (1-2)___ (2-3)___	UW W ___ x1 ___
Lower Anterior Segment	R (3-2)___ (2-1)___ (1-1)___ L (1-2)___ (2-3)___	___ x1 ___	R (3-2)___ (2-1)___ (1-1)___ L (1-2)___ (2-3)___	___ x1 ___
Right Buccal Occlusion	AP _____ Transverse _____ Vertical _____	___ x1 ___	AP _____ _____	___ x1 ___
Left Buccal Occlusion	AP _____ Transverse _____ Vertical _____	___ x1 ___	AP _____ _____	___ x1 ___
Overjet/Anterior Crossbite	_____/_____ _____	___ x6 ___	_____/_____ _____	___ x6 ___
Overbite/Open Bite	_____/_____ _____	___ x2 ___	_____/_____ _____	___ x2 ___
Centerline	_____ _____	___ x4 ___	_____ _____	___ x4 ___
Totals: _____			Totals: _____	

Measured Incisor Overjet

Percent Resolved: _____

_____ mm

Notation:

If the total score is less than the current PAR Index, MassHealth may consider additional information about the presence of other severe deviations. These deviations are considered severe if, left untreated, they would cause irreversible damage to the teeth and underlying structures (for example, presence of clefts or facial asymmetry). Record on form DEN-2 in Part II.

For MassHealth Use Only

Min. Index Score: ___W

Con. Score: ___

___Approved

___Denied

Con.#: ___ Init. _____

___Models Requested

Models Received

Date: _____

Code: _____

Date Received: _____

Date: _____

Date: _____